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HEALTHCARE

Johns Hopkins HealthCare LLC: Care Management and Care Coordination for Chronic Diseases

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Epidemiology

- Over 145 million people –(nearly half the population) - suffer from asthma, depression and other chronic conditions.
- Almost 48 million Americans report a disability related to chronic illness.
- 25% of U.S. adults have multiple chronic conditions
- The percentage of adults with 2 or more chronic conditions increases with age.
- Among older adults, 43% have 3 or more illnesses and 23% have more than five.

Community Health Partnership

Community Patient Characteristics

High Risk Group = 1000 PPMCO patients

Patient characteristics: Medical and Behavioral Conditions

36% have 6 or more chronic conditions.

Heart disease: 98%

- Conditions
  - Coronary Artery Disease (condition leading to heart attack): 58%
  - Heart Failure: 32%
- Modifiable risk factors
  - Hypertension: 84%
  - Smoking: 71%
  - High Levels of Cholesterol : 52%

Lung disease

- Asthma: 42%
- Emphysema: 29%

Kidney disease: 28%

Substance use

- Smoking: 71%
- Substance abuse: 45%
- Alcohol Abuse: 29%

Diabetes: 49%

Community Health Partnership

Community Intervention

BEGIN

Target Population
Attend one of the participating clinics within 7 zip codes

1. Member identified to be in **the top 20%** of people with a high risk of inpatient admission or ED Visit

2. A Clinical Screener will **verify eligibility** and complete Demographics and Health Status sections of assessment. Assigns to team.

3. Community Health Worker outreaches to **identify barriers** to getting Healthcare services and schedules follow up with Case Manager.

4. Case Manager Visit at clinic to complete **survey of health and behavioral needs.**

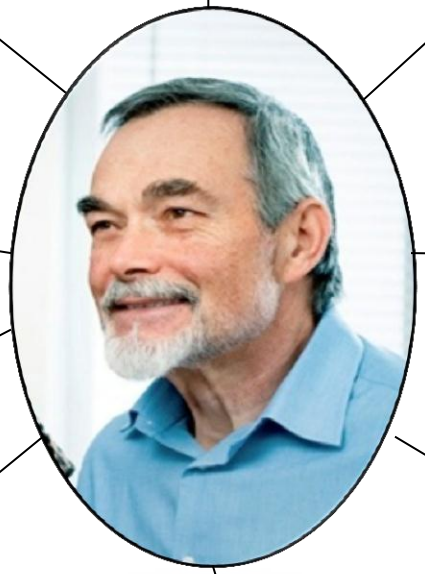
5. Visit with PCP and team at clinic to work on a **Care Plan** to identify goals and health care services needs.

6. Referral to members of the **JCHiP Team** for self-management education, behavioral support, or specialty care.

7. Ongoing relationship with team members in the clinic and community

GOALS

1. Improved Health care
2. Improved Experience with Healthcare system
3. Reduced Costs of Care



Care Management Overview

Case Management is a collaborative process that assesses, plans, coordinates, implements, monitors and evaluates the options and services required to meet the patients health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost effective interventions and outcomes (Commission on Case Management Certification, 2005).

Coordination of care is a cornerstone of case management practice. Care Coordination is a process that crosses through the JHM Care Management Continuum, and is the deliberate organization of patient care activities between two or more participants (or patients) involved in a patient's care to facilitate appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care (Agency for Health Care Research and Quality).

Care Management Overview

- Johns Hopkins HealthCare LLC has historically offered health management for Priority Partners, EHP and USFHP members at no cost to the member. The Care Management program has now been expanded to include JMAP members.

- Members are given a variety of support, tools and services that are specifically designed to help them better understand and manage their medical conditions. Our programs and services aim to educate, empower and inform your patients to be engaged in their health care through improved self-management. Members with complex medical conditions, or who have multiple conditions, such as adults with diabetes, asthma, chronic obstructive pulmonary disease (COPD), and/or congestive heart failure are contacted by a case manager who will assess their health status, work with them to develop a self-management plan, and assist them in getting the appropriate care.

Care Management Overview

- **LEVEL 1: Complex Case Management**

  This level is for members with **complex medical conditions** and/or multiple conditions. These members may be adults and children with diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD) and/or cardiovascular disease. Members in this level are contacted by a care manager who will assess their health status, work with them to develop a self-management plan, as well as help them get the right care.

Care Management Overview

- **LEVEL 2: Monitored Case Management**

  This level is for members with less complicated conditions, such as less severe asthma or diabetes. These members also have a risk for developing other conditions or complications, and can benefit from ongoing monitoring and help to stay on a healthy track. Care managers will work with these members to track their health status and needs over time. Care managers will also encourage progress and periodically provide health information about keeping a healthy lifestyle.

Care Management Overview

- **LEVEL 3: Lifestyle Management**

  This level is for members with conditions that are more easily kept under control. Some members will receive routine information about their condition. This material will help keep the member's self-management skills up-to-date so that they can continue to live full lives and avoid any complications

Care Management Overview

- **Other services provided by the program include:**
  - Periodic mailings of health educational materials
  - Communicating to the member and health care provider about medical and pharmacy claims
  - Use of the TeleWatch Health Monitoring System which allows members and their health care providers to monitor health conditions by telephone
  - Review of medications and discussion with our clinical pharmacists if needed
  - Outreach to eligible members as they leave inpatient care, ensuring they get the correct follow-up care and needed medical equipment
  - Help with discharge planning, care coordination, and member and family education when moving from a hospital to a lower level of care to home

Care Management Overview

Six Essential Activities of Case Management

- Assessment
- Planning
- Implementation
- Coordination
- Monitoring
- Evaluation

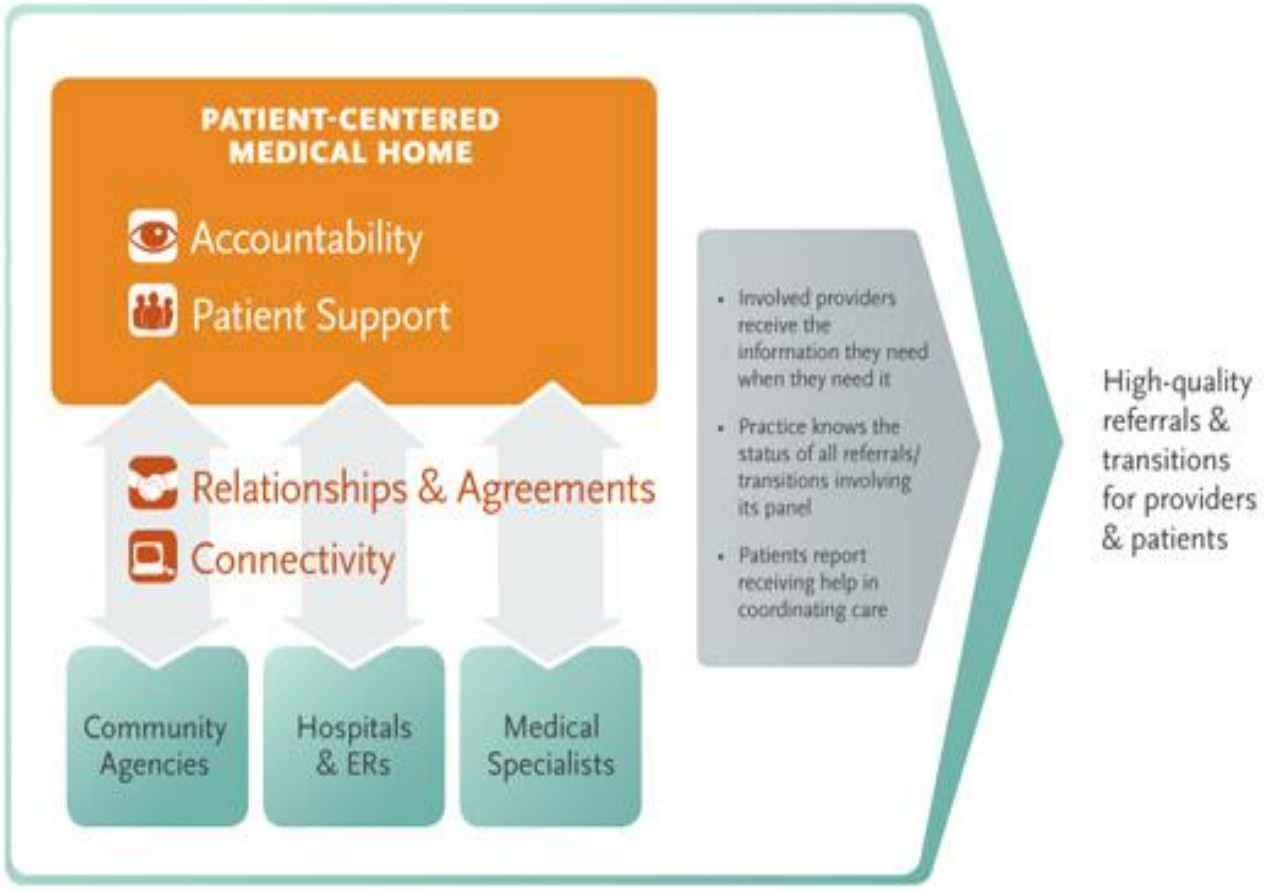
Goals of Case Management

- Improve quality of life
- Achieve the best possible clinical outcomes
- Improve the self management of diseases and conditions
- Reduce unplanned hospital admissions and emergency room usage
- Improve member's understanding of health condition
- Educate the member and family about preventative care and benefits
- Ensure care is delivered in the right setting, at the right time
- Data collection/documentation

What is coordinated care?

- Care that is coordinated across all elements of the broader healthcare system.
  - Information exchange is facilitated across providers and sites of care
  - Resources for patients and practitioners to support care management activities are provided

Care Coordination Model



7 Strategies for Care Coordination

- Work with broad stakeholder group to develop measures
- Clarify purpose of measurement: quality improvement, accountability, evaluation?
- Use standardized measures
- Incorporate patient feedback
- Develop a tracking system
- Build and nurture relationships with providers outside of the practice (“medical neighborhood”) to facilitate data sharing and monitoring
- Use data to improve care coordination

Johns Hopkins Medicine Alliance for Patients JMAP

ACO Basics

- The Affordable Care Act (ACA) created the **Medicare Shared Savings Program (MSSP).**
- **Accountable for the quality, cost and overall care** of a set of patients. Seek to **coordinate care.**
- **Provider Led.** ACOs involve a payer.
- **Voluntary** program; MSSP is Medicare "fee-for-service" beneficiaries ONLY.
- Patients pick **any doctor**. **No ACO "lock in" for patients.**
- **3 Year Agreement Period.**

How Will Providers & Patients Be Impacted?

PROVIDERS/PRACTICES

- All physicians included (primary or specialty)
- Billing is traditional fee-for-service
- No change in governance or management
- Patient and provider data reports
- ACO-related activities compliance with policies & procedures, such as:
  - Beneficiary communication
  - Reporting quality metrics
  - Care protocols/patient access
- Potential to receive shared savings

PATIENTS

- Patient-focused system of care
- See any doctor
- Standardized care and clinical protocols
- Care management
- Use patient data, assess outcomes
- Patient representatives in ACO governance
- JMAP 1-800 number (1-855-390-5803)
- Receive announcement letter and opportunity to opt-out of data sharing

JMAP Participants

- Johns Hopkins Community Physicians
- Johns Hopkins School of Medicine – Clinical Practice Association
- Columbia Medical Practice
- Potomac Physician Associates
- Cardiovascular Specialists of Central Maryland
- The Johns Hopkins Hospital
- Johns Hopkins Bay View Medical Center
- Howard County General Hospital
- Suburban Hospital
- Sibley Memorial Hospital

J-CHiP

Community Health Partnership

- Build on existing programs. Over 200 people involved.
- Will **transform patient care** across continuum: ***clinics, SNFs hospitals, home, and EDs***.
- **Catalyzed by** a three-year CMS grant of $19.9M.
- **East Baltimore Community** – 7 zip codes.

Community Health Partnership

- **STAR Community Health Workers (CHWs)**
  - Train 5 CHWs to deliver intensive, longitudinal community-based case management to high-risk patients residing in 3 target zip codes (21202, 21205, 21213)
  - Will be employed and overseen by STAR

- **MFC Neighborhood Navigators (NNs)**
  - Provide 30 NNs to conduct outreach, resource connection, and social support to neighbors who live on and around their blocks in one neighborhood within the target zip codes
  - Will receive stipends and support from MFC

How Physicians Get Paid

- Care Transition Codes- hospital to home or to another care setting, e.g. Skilled Nursing Facility
  - 99495 – requires documentation of medical discussion, not in person, with patient or caregiver within two business days of discharge
  - 99496- requires a face to face visit within a week.

Transition Care Codes (outside of face to face visits)

- 99487- Patient not seen by physician but instead by office staff who provide 1 hour over 30 days coordinating care
- 99488- Includes 1 hour of care coordination and a face to face visit
- 99489- Used in 30 min. increments over the initial hour of care coordination
- ***Very important to develop systems that track actual time spent.***
- ***Medicaid is budgeted to spend $600M on TC***

Guiding Prinicipals

- We believe that people can lead better, healthier lives.
- Providers who care for chronically ill patients can be better supported with evidence-based guidelines, specialty expertise, and information systems.
- Overall health care costs can be lowered through better care delivery.

Guiding Principals (cont)

- All of this is possible by transforming what is currently a reactive health care system into one that keeps its patients as healthy as possible through:
  - planning
  - proven strategies
  - management.
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Thank you for your attention!

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